recovery and those without. Logistic regressions fit via generalized estimating equations to account for repeated measurement over time were used to test the association of each factor and return of menses over the 18-month study.

Results: Subjects were aged 18 ± 2.8 years (mean ± SD), and self-identified primarily as white (86%). Sixty-five percent (n = 24) had recovery of menses during the study. Length of illness (19 ± 26 months) was similar between those subjects with menstrual recovery and those without, as was the duration of amenorrhea (20 ± 12 months) at baseline. Subjects exercised 7 ± 3 hours/week. Percentage body fat by DXA was associated with menstrual recovery [OR 1.19 (1.06, 1.33), $p < 0.01$], as were BMI [OR 1.48 (1.13, 1.95), $p < 0.01$] and percent median body weight [OR 1.09 (1.03, 1.16), $p = 0.004$]. Estradiol = 30ng/mL, alone, was not associated ($p = 0.08$), but when coupled with percent mean body weight it was an important predictor of menstrual recovery [OR 2.49 (1.09, 5.65), $p = 0.03$]. Changes in leptin levels were not associated with return of menses, but the sample size was small (n = 11). Serum cortisol levels and scores on both mental health screens were, similarly, not associated with return of menses.

Conclusions: While weight gain is an important goal of treatment in adolescents with anorexia nervosa, percentage body fat may be a useful clinical measure to follow to inform menstrual recovery and can be obtained at the same time as bone density measures.

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GIRL TALK: RELATIONAL AGGRESSION BY PEERS AS AN ANTECEDENT TO EATING DISORDERS AMONG GIRLS AND WOMEN

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Purpose: In spite of recent attention to bullying in childhood as a risk factor for later psychopathology, little research has explored how this relates to the development and maintenance of an eating disorder. Research by Groleau, et al. (2012) supports a relationship between childhood victimization by bullying and eating disorder development among women with bulimia. However, this relationship has not been examined among women with other eating disorders. In an effort to replicate and expand the findings by Groleau et al (2012), these researchers developed the present study. This poster presents results from a completed investigation of the relationship between childhood bullying (relational aggression) and the development and maintenance of eating disorders.

Methods: Two hundred and sixty-one adolescent girls and women (N = 261) who were receiving inpatient treatment at The Renfrew Center of Philadelphia or Coconut Creek consented to research, and completed self-report questionnaires about childhood histories of victimization by peer bullying, eating disorder symptoms, affective lability and self-esteem. Of these participants, 66 (25.3%) met DSM-IV criteria for Anorexia Nervosa, Restricting subtype, 32 (12.3%) for Anorexia Nervosa, Purging subtype, 92 (35.2%) for Bulimia Nervosa and 71 (27.2%) for Eating Disorder NOS. Chi-squared tests were used to compare childhood bullying frequencies between eating disorder diagnoses. Multiple regression analyses, following the guidelines of Baron and Kenny (1986), examined low self-esteem and affective lability as potential mediating factors between this history and the development and maintenance of an eating disorder.

Results: A history of childhood bullying in the form of verbal, physical, social, relational, and/or cyber-aggression was reported by 92% of participants. Frequency of childhood bullying between diagnostic groups was not significant. The proposed mediators of low self-esteem and affective lability were tested to determine whether they were predictive. Correlations revealed that childhood victimization by peer bullying was significantly related to affective lability, low self-esteem and eating symptoms. Multiple regression analyses revealed that eating symptoms were significantly predicted by the influences of affective lability and low self-esteem.

Conclusions: These findings demonstrate that histories of victimization by peer bullying are prevalent among women with eating disorders, beyond the scope of Groleau's (2012) population. This supports the importance of including questions about peer-initiated childhood bullying as an integral part of the assessment and treatment of eating disorders. While additional research can clarify the relative importance of factors such as bullying frequency, intensity and/or duration in accurately and adequately assessing the impact of being bullied on eating disorder development and maintenance, information about self-esteem and affective lability should also be included. Future research might also explore antecedents to low self-esteem and affective lability in family constellations, with a view to implementing effective interventions.

Sources of Support: Baron, R.M., Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. Journal of Personality and Social Psychology, 51, 1173-1182. Groleau, P., Steiger, H., Bruce, K., Israel, M., Sycz, L., Ouellete, A., Badawi, G. (2012). Childhood Emotional Abuse and Eating Symptoms in Bulimic Disorders: An Examination of Possible Mediating Variables, International Journal of Eating Disorders, 45, 326-332.

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EXAMINING THE USE OF MEAL SUPERVISION IN ADOLESCENTS AND YOUNG ADULTS WITH RESTRICTIVE EATING DISORDERS DURING MEDICAL HOSPITALIZATION

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Purpose: Weight restoration is the primary goal of medical hospitalization for patients with restrictive eating disorders; however, there is little evidence on best practices to achieve adequate weight gain during this time. Patients who restore weight at or close to ideal body weight have lower incidence of relapse following discharge, and improved long- and short-term outcomes. Although meal time can cause high anxiety, interventions during meal time may increase caloric intake and promote weight gain. The authors completed a chart review in 2008-2009 examining prevalence and effect of meal supervision during 52 patient admissions during which supervision was